

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Kingwood Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 1921 Northeast 21st Street Oklahoma City, OK 73111	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified when holding a medication without holding parameters for one (#23) of five sampled residents reviewed for unnecessary medications.</p> <p>The DON identified seven residents who received losartan potassium.</p> <p>Findings:</p> <p>A Resident's Family or Physician Notification of Change policy, dated 12/01/09, read in part, .This is a guideline to know when it may be necessary to notify the resident's family or physician .The facility will inform the resident; consult with the resident's physician .of the following events .A need to alter treatment significantly .need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment .</p> <p>Resident #23 had diagnoses which included essential hypertension.</p> <p>A Physician Order, dated 06/04/24, documented losartan potassium 50 mg give one tablet by mouth two times a day related to essential hypertension. The order was on hold from 10/28/24 at 12:58 p.m. to 10/30/24 at 12:57 p.m.</p> <p>The October 2024 MAR documented an 11 for the 7:00 a.m. to 11:00 a.m. dose of losartan potassium on 6th and 19th. It documented an 11 for the 6:00 p.m. to 10:00 p.m. dose of losartan potassium on the 1st, 3rd, 4th, 5th, 8th, 9th, 10th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 30th, and 31st. The chart codes documented an 11 meant vital signs outside parameters.</p> <p>There was no documentation the physician was notified prior to the facility holding this medication for the above administrations.</p> <p>The November 2024 MAR documented an 11 for the 7:00 a.m. to 11:00 a.m. dose of losartan potassium on the 2nd and the 3rd. It documented an 11 for the 6:00 p.m. to 10:00 p.m. dose of losartan potassium on the 1st, 2nd, 5th, 6th, 7th, 8th, 11th, 12th, 14th, 15th, 19th, 21st, and 25th. The chart codes documented an 11 meant vital signs outside parameters.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documentation the physician was notified prior to the facility holding this medication for the above administrations.</p> <p>On 12/06/24 at 11:03 a.m., LPN #6 stated staff were to use the punch initial give method when administering medication. They stated when they put an order in, it would show up on the MAR.</p> <p>On 12/06/24 at 11:05 a.m., LPN #6 stated if staff didn't administer a medication, they were to notify the nurse. They stated staff couldn't just hold a medication, as those instructions would come from the physician. They stated Resident #23 was to receive 50 mg of losartan potassium two times a day at 7:00 a.m. to 11:00 a.m. and 6:00 p.m. to 10:00 p.m.</p> <p>On 12/06/24 at 11:09 a.m., LPN #6 stated they did not see any holding parameters for the medication.</p> <p>On 12/06/24 at 11:10 a.m., LPN #6 reviewed the November 2024 MAR for Resident #23 and stated the 11's meant vital signs outside of parameters.</p> <p>On 12/06/24 at 11:12 a.m., LPN #6 reviewed the October 2024 MAR and identified all of the 11's documented for the losartan potassium. They stated they did not see where the physician was contacted when this medication was held.</p> <p>On 12/06/24 at 11:50 a.m., the Regional Nurse Consultant stated the electronic record system showed every resident with medications due for the shift. The Administrator stated the physician would be notified when a medication was held and the reason.</p> <p>On 12/06/24 at 11:51 a.m., the DON stated Resident #23 received losartan potassium 50 mg twice a day at 7:00 am to 11:00 a.m. and 6:00 p.m. to 10:00 p.m.</p> <p>On 12/06/24 at 11:55 a.m., the DON stated the losartan potassium did not have holding parameters. The DON reviewed the October 2024 MAR and the November 2024 MAR and stated 11 meant vital signs were outside parameters.</p> <p>On 12/06/24 at 11:59 a.m., the DON was asked if the physician was notified when the medication was held. The DON and the Regional Nurse Consultant stated there were standing orders to hold for a low blood pressure. The Regional Nurse Consultant stated the physician didn't want to be notified every time the resident had a low blood pressure.</p> <p>Standing orders to hold this medication were never provided to the survey team.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>34460</p> <p>On 12/10/24 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure their abuse policy was followed.</p> <p>On 12/10/24, the Oklahoma State Department of Health verified the existence of an IJ situation.</p> <p>On 12/10/24 at 1:13 p.m., the administrator was notified of the immediate jeopardy situation.</p> <p>On 12/11/24 at 8:41 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health.</p> <p>The facility plan of removal documented:</p> <p>On 12/10/24, The facility will ensure residents are free from abuse, neglect, and misappropriation of resident property and exploitation.</p> <ol style="list-style-type: none"> 1) Resident #117 assessed by APRN for any signs of sexual abuse and orders to be followed for further treatment or evaluation. 2) Resident #53 was placed on one-on-one increased supervision on 12/09/2024 at approximately 12:30 p.m. 3) The OKC police department was notified of an allegation of sexual abuse on 12/09/2024 at 1:47 p.m. 4) All nursing staff were in-serviced on the abuse, neglect, and misappropriation policies and procedures and ensure residents are free from abuse, neglect, and misappropriation by midnight on 12/09/2024. Any nursing staff not currently in the facility will be in-serviced before returning to work. 5) Staff members interviewed regarding any allegations of sexual abuse on 12/09/2024 no allegations reported. 6) Safe survey interview conducted with all residents with a BIMs of 9 or higher on 12/09/2024 no allegations reported. 7) Appropriate staff members suspended pending investigation of allegation. 8) Residents who are not able to be interviewed will be assessed for any signs of abuse. 9) Follow up assessments initiated every shift for Resident #117. 10) The likelihood for serious harm to any recipient no longer exists effective 12/9/2024. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The IJ was lifted, effective 12/11/24 at 6:48 p.m., when all components of the plan of removal had been completed. The deficient practice remained as isolated potential for harm to the residents.</p> <p>Based on interview and record review, the facility failed to implement the reporting of their sexual abuse allegation policy for one (#117) of four residents reviewed for abuse.</p> <p>The Administrator identified 67 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's abuse policy, dated 11/02/24, read in part, .All employees of a nursing facility are mandated reporters of resident abuse, to appropriate personnel .and must report any and all incidents. All employees shall report any reasonable suspicion of a crime against any individual who is a resident of the facility without fear of retaliation .</p> <p>1. Resident #117 had diagnoses to include hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body which could affect the arms, legs, and facial muscles) following cerebral infarction affecting right dominant side.</p> <p>A Quarterly Assessment, dated 11/07/24, documented Resident #117 had no speech, was rarely or never understood, and rarely or never understands, BIMS score 99 (resident unable to complete interview), had severely impaired cognition ability to make daily decisions, had functional limitations to range of motion which included upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremity impairment to one side. Resident #117 was dependent on staff for ADL's which included bathing, dressing, toileting/incontinent care, transfers, repositioning, and locomotion of manual wheel chair.</p> <p>2. Resident #53 had diagnoses to include encephalopathy with hemiplegia and hemiparesis.</p> <p>A Quarterly Assessment, dated 10/21/24, documented Resident #53 had a BIMS of 07 which indicated severe cognitive impairment. Resident #53 was able to self propel in a manual wheel chair with upper and lower extremity impairment to one side.</p> <p>A Care Plan, dated 12/02/24, documented Resident #53 had behaviors, undesirable behaviors would be monitored and managed, ensure the safety of Resident and others, establish boundaries and limits with Resident, evaluate medications, and inappropriate gestures.</p> <p>35389</p> <p>On 12/03/24 at 9:08 a.m., CNA #2 stated Resident #53 wheeled themselves into Resident #117's room and they had to remove Resident #53 from Resident #117's room at least 10 times. They stated the facility did not want the family to know.</p> <p>On 12/03/24 at 9:39 a.m., Res #117 was observed sitting in w/c, in the lobby, awake, alert, unable to answer yes or no questions, does not shake head yes or no, and not verbal.</p> <p>On 12/03/24 at 10:12 a.m., CNA #2 stated Resident #117's family did not know they were getting raped because the facility staff tried to hide it so they won't get in trouble.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/03/24 at 10:30 a.m., CNA #2 stated there were other staff members who wanted to speak to the survey team, but they were afraid of losing their job.</p> <p>On 12/03/24 at 10:45 a.m., CNA #3 stated Resident #53 was on Hall 400 but was moved to Hall 300 to make sure they were not around Resident #117. CNA #3 stated they had witnessed Resident #53 in Resident #117's room.</p> <p>On 12/03/24 at 11:23 p.m., CNA #10 stated they had seen Resident #53 transfer themselves, and the resident had taken themselves to the bathroom at times. They stated they were unsure of the reason the resident had changed halls.</p> <p>On 12/04/24 at 9:36 a.m., Resident #53 was observed transferring themselves from their bed into their manual wheelchair.</p> <p>On 12/04/24 at 9:45 a.m., Resident #53 stated they were able to transfer to the wheelchair on their own. They stated they went to the restroom on their own and got dressed on their own.</p> <p>On 12/04/24 at 9:48 a.m., Resident #53 was observed propelling themselves in the wheelchair out of their bedroom and down Hall 300, and into the dining room area independently.</p> <p>On 12/04/24 at 9:51 a.m., Resident #53 wheeled themselves over to the hydration station and obtained a cup of liquid out of the coffee machine on their own and placed in on the table.</p> <p>On 12/04/24 at 10:03 a.m., Resident #117 was accompanied by staff to the dining area.</p> <p>On 12/04/24 at 10:14 a.m., Resident #53 wheeled themselves close to the front foyer area.</p> <p>On 12/04/24 at 10:16 a.m., Resident #53 was observed in the front television room where Resident #117 was located.</p> <p>On 12/04/24 at 10:20 a.m., Resident #117 was seated in a red wheelchair in the television room with their eyes closed. No staff was observed approaching either resident.</p> <p>On 12/04/24 at 10:24 a.m., Resident #117 was observed with their eyes open, and began rubbing their left inner thigh and upper leg looking in the direction of Resident #53 and continued to rub their left leg and knee. Resident #53 was seated approximately six feet away from Resident #117. No staff were observed to approach either resident.</p> <p>On 12/04/24 at 10:07 a.m., CNA #1 stated Resident #53 was moved off the hall because they wandered into other Resident's rooms. CNA #1 stated Res #53 liked to go into Resident #117's room. My nurses have pulled him out of room. CNA #1 stated they didn't know if anything happened between them. They never saw anything. CNA #1 stated Resident #53 was fully clothed, but Resident #117 was not when they were in bed.</p> <p>On 12/04/24 at 10:31 a.m., Resident #117 continued to rub on their left upper thigh down to their knee looking in the direction of Resident #53. Resident #53 wheeled themselves away from the living room area.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/04/24 at 10:51 a.m., CNA #9 stated Resident #53 was pretty self-sufficient as far as transfers and toileting. They stated if they observed any signs or symptoms of abuse, they would report it to the charge nurse.</p> <p>On 12/04/24 at 11:16 a.m. Resident #117 was observed sitting in their w/c at a table playing bingo with staff.</p> <p>On 12/05/24 at 6:14 a.m., RN #1 stated Resident #53 was a wanderer. They stated the resident had been a wanderer since they had worked at the facility. They stated they know Resident #53 wandered the Halls and would come down Hall 400. They stated they know the resident had tried to go into one or two female residents' rooms before, but they were unsure of whom. They stated they were unaware of any sexual behaviors between Resident #53 and other residents.</p> <p>On 12/05/24 at 6:18 a.m., RN #1 stated if abuse was reported to them, they would call their boss. They stated if it was a resident touching another resident physically or verbally, they would call the police immediately. They stated they would report it to the DON and the Administrator and document it under behaviors.</p> <p>On 12/06/24 at 11:45 a.m., MDS Coordinator #1 stated they were asked by the DON to update their care plan. MDS Coordinator#1 stated if the resident had a behavior it would be documented in a behavior note, but they hadn't seen any behavior notes documented. MDS Coordinator #1 stated they didn't know what behaviors were exhibited if there were no notes documented.</p> <p>On 12/06/24 at 11:52 a.m., MDS Coordinator #2 stated Resident #53 could get up and use the bathroom themselves, but they were unsteady and needed assistance.</p> <p>On 12/06/24 at 11:53 a.m., MDS Coordinator #1 stated Resident #53 would sometimes move in bed sometimes would not. They stated Resident #53 could sit to stand, but needed assistance and could transfer independently, but just depended on them.</p> <p>On 12/06/24 at 12:40 p.m., the DON stated Resident #53's behavior included refusal of incontinent care.</p> <p>On 12/06/24 at 12:41 p.m., the regional nurse consultant stated behaviors were documented on the TAR, psych doctor notified, medications reviewed, Paxil reviewed. The regional nurse consultant stated inappropriate gestures included gesture with hand, like no, as if going to hit or refuse.</p> <p>On 12/06/24 at 2:39 p.m., RN #2 stated they were told Resident #53 got away with it and always tried to get the female resident down in a room by themselves.</p> <p>On 12/06/24 at 2:46 p.m., RN #2 stated the female resident Resident #53 molested was in a wheelchair. RN #2 stated they heard in passing Resident #53 was found in the female resident's room again and the staff pushed Resident #53 out. RN #2 stated if a staff member reported abuse, they would notify the Administrator. RN #2 stated the abuse was never reported to them, or they would have called Administration or the police. They stated they were unsure if anyone charted the rape or Resident #53's sexual behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/06/24 at 2:53 p.m., RN #2 stated the reason Resident #53 was moved from Hall 400 to Hall 300 was because the resident was trying to get to the female resident. They stated the move was to get Resident #53 away from the female resident.</p> <p>On 12/09/24 at 1:16 p.m., the Administrator stated if their staff overheard a male resident was getting a female resident into a room, raped they would fully expect the alleged be assessed, police called and they would expect to be notified. The Administrator stated if they heard a male resident had sex with a female resident, it would depend on the residents, some are able to consent. We would look at BIMs scores. Residents have a right to conjugal visits if they are not in a room by their self. The Administrator stated if staff had told them a male resident had touched a females breast and had sex with them, they would expect both staff in their office, if it was not consensual, the abuse coordinator or DON would be notified with the alleged (victim) safe and other resident put on observation, relocate, and start investigation. The Administrator stated the staff should be following the abuse policy. Everyone in here should be following my abuse policy. The Administrator stated they would report who, where, what, when, inservice staff on abuse, and refresh who staff should report to. They all know who the chain of command are. The Administrator stated they would report an allegation of abuse within a two hour window, start an investigation and alert the authorities.</p> <p>On 12/09/24 at 2:28 p.m., RN #2 stated they overheard the Administrator say to keep an eye on him (#53). They were just coming in to work and the Administrator had staff at the nurses station.</p> <p>On 12/10/24 at 11:33 a.m., Family Member #1 stated to their knowledge Resident #53 was moved to a new room due to a disagreement with a roommate that was a bit aggressive. They stated the move was to help with the resolution.</p> <p>On 12/11/24 at 12:22 p.m., the Corporate Administrator stated they didn't need to print a resident list for those with a BIMS of nine or higher because all the residents who were below a nine were provided their assessments. They stated the only staff member suspended was the Administrator on 12/10 and they returned to work on 12/10.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46216</p> <p>Based on record review and interview, the facility failed to report an allegation of resident to resident abuse to OSDH for two (#25 and #39) of four sampled residents reviewed for abuse.</p> <p>The Administrator identified 67 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's Resident Abuse, Neglect, and Misappropriation of Property policy, revised 11-01-22, read in part, The resident has the right to be free from verbal, sexual, physical, and mental abuse. The policy also read, All employees of a nursing facility are mandated reporters of resident abuse, neglect or misappropriation of property, as well as reasonable suspicion of a crime against a resident and must report any and all incidents. The policy also read, All allegations and incidents of abuse, neglect or misappropriation of resident's property, must be reported to QAPI committee, appropriate Federal and State Agencies including OSDH and investigated to establish a reasonable conclusion about the validity of the allegation.</p> <p>1. Resident #25 had diagnosis which included schizophrenia.</p> <p>The 5-day resident assessment, dated 12/08/24, documented Resident #25's cognition was intact and Resident #25 had hallucinations and delusions</p> <p>2. Resident #39 had diagnoses which included Alzheimer's disease and unspecified mood [affective] disorder.</p> <p>The quarterly resident assessment, dated 07/13/24, documented Resident #39's cognition was moderately impaired and Resident #39 had no behavioral symptoms.</p> <p>An Incident Report, dated 08/04/24, documented, This nurse noted Resident #39 bleeding from their left cheekbone at 9:30 a.m., when asked Resident #39 said someone hit them but they did not know who did, another resident from hall 100 stated it was Resident #25. The facility spoke to Resident #25 and they stated Resident #39 was in their way. The residents were immediately separated from each other and Resident #39 was to be monitored closely. Head to toe assessment done, skin tear noted to left cheekbone.</p> <p>There was no documentation an incident report was sent to OSDH.</p> <p>On 12/10/24 at 12:34 p.m., the Administrator stated they were unable to find a reportable on this incident and she would need to call the DON.</p> <p>On 12/10/24 at 12:34 p.m., the Administrator stated it was a resident to resident incident.</p> <p>On 12/10/24 at 12:59 p.m., the Administrator stated she had spoken to the DON and there was not a state report done, only the incident report.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>46216</p> <p>Based on record review and interview, the facility failed to conduct a thorough investigation after an allegation of resident to resident abuse for two (#25 and #39) of four sampled residents reviewed for abuse.</p> <p>The Administrator identified 67 residents resided in the facility.</p> <p>Findings:</p> <p>A Resident Abuse, Neglect and Misappropriation of Property policy, revised 11-02-22, read in part, A member of the administrative staff will then conduct thorough investigation of the incident/allegation to obtain information about the incident and complete the ODH-283. The policy also read, Upon receiving an allegation of resident abuse .The facility will begin an investigation of the incident .All allegations and incidents of abuse .must be reported to QAPI committee, appropriate Federal and State agencies including OSDH and investigated to establish a reasonable conclusion about the validity of the allegation.</p> <p>1. Resident #25 had diagnosis which included schizophrenia.</p> <p>The 5-day resident assessment, dated 12/08/24, documented Resident #25's cognition was intact and Resident #25 had hallucinations and delusions</p> <p>2. Resident #39 had diagnoses which included Alzheimer's disease and unspecified mood [affective] disorder.</p> <p>The quarterly resident assessment, dated 07/13/24, documented Resident #39's cognition was moderately impaired and Resident #39 had no behavioral symptoms.</p> <p>An Incident Report, dated 08/04/24, documented, This nurse noted Resident #39 bleeding from their left cheekbone at 9:30 a.m., when asked Resident #39 said someone hit them but they did not know who did, another resident from hall 100 stated it was Resident #25. The facility spoke to Resident #25 and they stated Resident #39 was in their way. The residents were immediately separated from each other and Resident #39 was to be monitored closely. Head to toe assessment done, skin tear noted to left cheekbone.</p> <p>On 12/10/24 at 12:59 p.m., the Administrator stated she had spoken to the DON and there was not an investigation done, only the incident report.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389</p> <p>Based on record review and interview the facility failed to ensure resident assessments were accurately coded for two (#16 and #23) of 23 sampled residents reviewed for resident assessments.</p> <p>The Administrator identified a census of 67. Corporate Nurse Consultant #1 identified three residents with colostomies resided in the facility.</p> <p>Findings:</p> <p>1. Resident #23 had diagnoses which included edema and end stage renal disease.</p> <p>Resident #23's weight record documented on:</p> <p>a. 11/02/23 296.2 pounds;</p> <p>b. 01/27/24 287.4 pounds;</p> <p>c. 04/02/24 296.2 pounds;</p> <p>d. 04/26/24 264.4 pounds;</p> <p>e. 05/02/24 272.2 pounds;</p> <p>f. 06/26/24 244 pounds;</p> <p>g. 07/26/24 241 pounds;</p> <p>h. 09/26/24 244 pounds; and</p> <p>i. 10/26/24 237.6 pounds.</p> <p>A Significant Change Resident Assessment, dated 05/02/24, documented Resident #23's height was 70 inches and weight was 272 pounds. It documented no or unknown for weight loss of five percent or more in the last month or ten percent or more in the last six months. It documented no or unknown for weight gain of five percent or more in the last month or ten percent or more in the last six months.</p> <p>A Quarterly Resident Assessment, dated 07/26/24, documented Resident #23's height in inches was 70 and weight was 242. It documented no or unknown for weight loss of five percent or more in the last month or ten percent or more in the last six months. It documented no or unknown for weight gain of five percent or more in the last month or ten percent or more in the last six months.</p> <p>A Quarterly Resident Assessment, dated 10/26/24, documented Resident #23's height was 74 inches and weight was 238 pounds.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/06/24 at 11:27 a.m., MDS Coordinator #2 stated they completed a risk assessment, spoke with residents, completed a brief interview for mental status, a risk assessment, and spoke with staff to ensure their resident assessments were accurately coded.</p> <p>On 12/06/24 at 11:28 a.m., MDS Coordinator #2 stated they reviewed resident weights in the electronic charting system to determine if a resident experienced weight loss or gain. They stated on Resident #23's significant change resident assessment dated [DATE], the resident had a height of 70 inches and weight of 272 pounds. MDS Coordinator #1 and MDS Coordinator #2 stated the assessment marked no for weight loss or weight gain.</p> <p>On 12/06/24 at 11:29 a.m., MDS Coordinator #1 stated on Resident #23's quarterly resident assessment dated [DATE], the resident had a height of 70 inches and 242 pounds. MDS Coordinator #1 stated it documented the resident had not experienced weight loss or gain. MDS Coordinator #2 stated the 07/27/24 should have documented weight loss.</p> <p>On 12/06/24 at 11:34 a.m., MDS Coordinator #1 stated Resident #23's quarterly resident assessment dated [DATE] documented a height of 74 inches and a weight of 238 pounds. MDS Coordinator #1 stated it documented no for weight loss or gain. MDS Coordinator #2 stated it should have documented weight loss as well.</p> <p>34460</p> <p>2. Resident #16 had a diagnoses which included a colostomy status.</p> <p>An Annual Resident Assessment, dated 11/22/24, documented Resident #16 did not have an ostomy or colostomy.</p> <p>On 12/11/24 at 11:03 a.m., MDS Coordinator #1 stated Resident #16 bowel continence was not rated because it was not marked. MDS Coordinator #2 stated Resident #16 had a colostomy.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>35389</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and interview the facility failed to coordinate care with a third party provider for one (#37) of three sampled resident reviewed for coordination of care.</p> <p>The DON identified one resident on (name-deleted) third party services resided in the facility.</p> <p>Findings:</p> <p>A contract between the facility and the third party provider, dated 12/16/16, read in part, .Medically Necessary Services shall mean those Covered Services provided by a health facility or health professional and which are appropriate for the symptoms and diagnosis and treatment of a condition .Provider agrees to . To render Covered Services to Participants only if Provider has obtained written authorization for such services from (third party provider) physician as described below .a (third party provider) physician must previously authorize all Covered Services in writing .</p> <p>Resident #37 had diagnoses which included major depressive disorder, liver disease, and unspecified viral hepatitis b without hepatic coma.</p> <p>A third party provider Communication Form, dated 07/05/24, documented Resident #37 needed labs and clarification on their chronic hepatitis b diagnoses. The form was signed by Provider #1.</p> <p>A third party provider Communication Form, dated 07/08/24, documented Resident #37 needed labs and documented the following new orders: CMP, Lipid, Hepatitis Panel, CBC, Prealbumin, Ferritin, Hem A1C, Iron and Total Iron Binding Capacity, Magnesium, TSH with T4 Free, PTH Intact and Calcium, and Vitamin D 25 Hydroxy with total 12 labs written at the bottom.</p> <p>A laboratory slip, dated 07/08/24, documented the above labs were ordered by Provider #1 for Resident #37.</p> <p>There was no documentation the above labs were collected for Resident #37.</p> <p>On 12/05/24 at 8:19 a.m., LPN #6 stated staff would note an order first, put the ordered labs in the electronic lab system to be drawn, and document the date and time the lab showed up to the facility. They stated they would print it out and verify the lab was drawn. They stated the lab tech would place a copy of what was drawn in the lab book which stayed at the nurses' station.</p> <p>On 12/05/24 at 8:21 a.m., LPN #6 stated when lab results came in, staff would look them up in the lab portal electronically. They stated the provider came to the facility on Tuesday and Thursday and staff would place the results in the communication book for them to review. LPN #6 stated if the provider did not come to the facility that day, they would call the results to the provider.</p> <p>On 12/05/24 at 8:22 a.m., LPN #6 stated after the provider reviewed the labs, they would write an order on the lab slip. They stated staff would then transcribe the order and send it to pharmacy. They stated the lab results would go in the resident's chart.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 8:24 a.m., LPN #6 reviewed the third party provider communication form dated 07/08/24 and stated, Wow 12 labs well lets look. LPN #6 went over to the computer and pulled up the lab system and stated they did not see a record for the labs. They stated the third party provider was an outside provider the resident would go and see. LPN #6 stated no one had noted the order.</p> <p>On 12/05/24 at 8:37 a.m., the Administrator stated the third party provider saw the resident monthly. The Administrator stated the third party provider provided Resident #37's medications, prescriptions and evaluations. They stated the resident went to the third party providers facility monthly and yearly.</p> <p>On 12/05/24 at 11:37 a.m., the DON stated the third party provider managed Resident #37's labs. They stated whenever the resident would see the provider, they would let the facility know if they were supposed to draw the labs. They stated they didn't. The DON stated they had called Physician #1 and lab came out today to draw the labs stat.</p> <p>On 12/05/24 at 11:40 a.m., the Regional Nurse Consultant stated the note was notification of what they were doing for the resident. The DON stated the forms were what the third party provider sent the facility for records of what they were doing.</p> <p>On 12/05/24 at 11:46 a.m., Third Party Representative #1 stated when they provided a lab slip to the facility, part of the contract was for the facility to complete the lab and send them the results. They stated if they left a lab slip and gave the order, that was for the facility to fill and the order needed to be drawn, They stated the facility was responsible for going over the labs needed with their provider, verifying it, having it drawn, and sending the results back to them.</p> <p>On 12/05/24 at 1:12 p.m., Third Party Representative #1 called back and stated both them and the facility had dropped the ball. They stated they had residents who had labs drawn there and also had residents who had labs drawn through the facility. They stated the biggest problem was the above labs were never drawn. They stated it was a lack of communication on both sides that caused the situation.</p> <p>On 12/06/24 at 8:35 a.m., the Administrator stated the facility had terminated all contracts with the third party provider except for Resident #37 because they had had a lot of issues. They stated the facility did not have a coordination of care policy. They stated they went by the contract.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>Based on record review and interview, the facility failed to ensure resident were transferred safely with a mechanical lift for one (#217) of one resident sampled resident reviewed for mechanical transfers.</p> <p>The Administrator identified 67 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #217 had diagnoses which included Alzheimer's disease and muscle weakness.</p> <p>A quarterly resident assessment dated [DATE], documented Resident #217 was dependent upon staff for all transfers.</p> <p>An Incident Note, dated 10/28/24 at 6:15 p.m., documented, This nurse was summoned by CNA to Resident #217's room. When this nurse arrived the Resident was laying on their back by the sink, another CNA at their side to console this Resident. This nurse asked what happened. CNA stated we were trying to transfer them to their bed and the feet of the lift got hung under the geri chair. We were trying to get the feet free of the geri chair and the weight of the resident rocking back and forth caused the lift to flip over and they landed there (pointing at the resident on the floor). This nurse asked the aides did they hit their head. They both stated that it happened so fast, but did not notice. Neurological checks: WNL for this resident's ability. Head to toe assessment was done with no evitable injuries noted. This nurse contacted doctors on call and new order was given to send resident to ER for further treatment and evaluation. Residents family member [name withheld] was contacted and notified of incident.</p> <p>In-services regarding proper lift use were conducted on 10/28, 10/29, and 10/30/24.</p> <p>Resident #217's care plan, revised on 11/19/24, documented Resident #217 is to have three person assist with transfers.</p> <p>On 12/11/24 at 11:14 a.m., CNA #1 stated the policy for using the lift was to have another staff member with you. They stated they had been in-serviced on lift use.</p> <p>On 12/11/24 at 11:20 a.m., CNA #5 stated they had been in-serviced on lift use about a month ago. They stated the policy for using the lift was two persons at all times.</p> <p>On 12/11/24 at 11:25 a.m., CMA #2 stated the policy for using the lift was to always have two staff members. They stated they had received in-service on lift use recently.</p> <p>On 12/11/27 at 11:27 a.m., LPN #6 stated the policy for using the lift was two persons at all times and to tell the resident what you are doing and keep them comfortable.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/11/24 at 11:29 a.m., the Administrator stated QA was involved by going over policies and incidents.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to coordinate care with a dialysis provider for one (#23) of one sampled resident reviewed for dialysis.</p> <p>The DON identified four residents who received dialysis services resided in the facility.</p> <p>Findings:</p> <p>A Guideline for Dialysis After Care policy, effective 07/11/12, read in part, . Schedule visits to Dialysis Center and coordinate care accordingly .</p> <p>Resident #23 had diagnoses which included end stage renal disease and essential hypertension.</p> <p>A Physician Order, dated 06/04/24, documented Resident #23 went to an outside dialysis provider on Tuesday, Thursday and Saturday.</p> <p>A Physician Order, dated 06/04/24, documented losartan potassium 50 mg give one tablet by mouth two times a day related to essential hypertension. The order was on hold from 10/28/24 at 12:58 p.m. to 10/30/24 at 12:57 p.m.</p> <p>A Physician Order, dated 06/04/24, documented minoxidil 2.5mg give one tablet by mouth one time a day related to essential hypertension. The October, November, and December 2024 MAR documented this medication was administered during the 7:00 a.m. to 11:00 a.m. timeframe.</p> <p>A Physician Order, dated 06/04/24, documented nifedipine ER 90 mg give one tablet by mouth one time a day related to essential hypertension. The October, November, and December 2024 MAR documented this medication was administered during the 7:00 a.m. to 11:00 a.m. timeframe.</p> <p>A communication form from the outside dialysis center, undated, read in part, Please be advised that this patient should NOT be receiving HTN drugs prior to dialysis on dialysis days, this prevents the removal of excess fluids due to hypotension .</p> <p>On 12/02/24 at 9:54 a.m., Resident #23 stated they attended dialysis on Tuesday, Thursday, and Saturday. They stated they left the facility around 8:30 in the morning and returned around 2:00 p.m.</p> <p>On 12/06/24 at 10:51 a.m., LPN #6 stated Resident #23 went to dialysis on Tuesday, Thursday, and Saturday in the morning. They stated the resident returned around 1:30 p.m. They stated they were working yesterday when the resident returned form dialysis.</p> <p>On 12/06/24 at 10:52 a.m., LPN #6 stated the facility coordinated care with the dialysis center by sending the dialysis communication sheet with the resident for the dialysis center to complete their part. They stated if the dialysis center had any orders, they would send them back with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/06/24 at 11:05 a.m., LPN #6 identified Resident #23 received a clonidine patch weekly on Wednesday, losartan potassium 50mg twice a day at 7:00 a.m. to 11:00 a.m. and 6:00 p.m. to 10:00 p.m., nifedipine ER 90 mg daily at 7:00 a.m. to 11:00 a.m., and minoxidil 2.5 mg daily at 7:00 a.m. to 11:00 a.m. to treat hypertension.</p> <p>On 12/06/24 at 11:14 a.m., LPN #6 reviewed the dialysis communication form and stated they did not know where the note came from or when it got in the resident's chart.</p> <p>On 12/06/24 at 11:38 a.m., the DON stated Resident #23 went to dialysis on Tuesday, Thursday, and Saturday in the morning and arrived back to the facility in the afternoon.</p> <p>On 12/06/24 at 11:40 a.m., the DON stated the facility would send the dialysis communication form with the resident. They stated if there were any new orders, they would send them back with the resident. The DON stated the facility would also call the dialysis center if they received new orders for the resident.</p> <p>On 12/06/24 at 12:05 p.m., the DON was asked to explain the undated dialysis communication form that documented Resident #23 should not be receiving HTN drugs prior to dialysis. The Regional Nurse Consultant stated an RN was who wrote the note and the RN was not a doctor and was working outside of their practice. They were asked if the physician was made aware of the recommendation from the dialysis center. The Regional Nurse Consultant stated they would have to pull progress notes. The DON stated the note wasn't even dated.</p> <p>On 12/06/24 at 12:09 p.m., the DON walked over to the medical records department in search of provider visits for Resident #23.</p> <p>On 12/06/24 at 12:21 p.m., after going through stacks of papers, Medical Records stated they had not located any additional provider visits for Resident #23.</p> <p>On 12/10/24 T 10:44 a.m., Dialysis Representative #1 stated they were familiar with Resident #23. They stated generally the dialysis center had all residents hold all blood pressure medications except coreg or carvedilol whether they had low blood pressure or not so they could remove excess fluids. They stated they would instruct residents to take blood pressure medications after the treatment was completed.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to ensure medications were administered as ordered for one (#23) of five sampled residents reviewed for unnecessary medications.</p> <p>The DON identified seven residents who received losartan potassium.</p> <p>Findings:</p> <p>A Preparation and General Guidelines policy, dated 01/22, read in part, .Medications are administered as prescribed in accordance with good nursing principles and practices .If a dose of regularly scheduled medication is withheld .If two consecutive doses of a vital medication are withheld .the physician is notified. Nursing documents the notification and physician response .</p> <p>Resident #23 had diagnoses which included essential hypertension.</p> <p>A Physician Order, dated 06/04/24, documented losartan potassium 50 mg give one tablet by mouth two times a day related to essential hypertension. The order was on hold from 10/28/24 at 12:58 p.m. to 10/30/24 at 12:57 p.m.</p> <p>The October 2024 MAR documented an 11 for the 7:00 a.m. to 11:00 a.m. dose of losartan potassium on 6th and 19th. It documented an 11 for the 6:00 p.m. to 10:00 p.m. dose of losartan potassium on the 1st, 3rd, 4th, 5th, 8th, 9th, 10th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 30th, and 31st. The chart codes documented an 11 meant vital signs outside parameters.</p> <p>There was no documentation an order to hold this medication was obtained prior to the facility holding this medication for the above administrations.</p> <p>The November 2024 MAR documented an 11 for the 7:00 a.m. to 11:00 a.m. dose of losartan potassium on the 2nd and the 3rd. It documented an 11 for the 6:00 p.m. to 10:00 p.m. dose of losartan potassium on the 1st, 2nd, 5th, 6th, 7th, 8th, 11th, 12th, 14th, 15th, 19th, 21st, and 25th. The chart codes documented an 11 meant vital signs outside parameters.</p> <p>There was no documentation an order to hold the medication was obtained prior to the facility holding this medication for the above administrations.</p> <p>On 12/06/24 at 11:03 a.m., LPN #6 stated staff were to use the punch initial give method when administering medication. They stated when they put an order in, it would show up on the MAR.</p> <p>On 12/06/24 at 11:05 a.m., LPN #6 stated if staff didn't administer a medication, they were to notify the nurse. They stated staff couldn't just hold a medication, as those instructions would come from the physician. They stated Resident #23 was to receive 50 mg of losartan potassium two times a day at 7:00 a.m. to 11:00 a.m. and 6:00 p.m. to 10:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/06/24 at 11:09 a.m., LPN #6 stated they did not see any holding parameters for the medication.</p> <p>On 12/06/24 at 11:10 a.m., LPN #6 reviewed the November 2024 MAR for Resident #23 and stated the 11's meant vital signs outside of parameters.</p> <p>On 12/06/24 at 11:12 a.m., LPN #6 reviewed the October 2024 MAR and identified all of the 11's documented for the losartan potassium. They stated they did not see where the facility received an order to hold the medication.</p> <p>On 12/06/24 at 11:50 a.m., the Regional Nurse Consultant stated the electronic record system showed every resident with medications due for the shift. The Administrator stated the physician would be notified when a medication was held and the reason.</p> <p>On 12/06/24 at 11:51 a.m., the DON stated Resident #23 received losartan potassium 50 mg twice a day at 7:00 am to 11:00 a.m. and 6:00 p.m. to 10:00 p.m.</p> <p>On 12/06/24 at 11:55 a.m., the DON stated the losartan potassium did not have holding parameters. The DON reviewed the October 2024 MAR and the November 2024 MAR and stated 11 meant vital signs were outside parameters.</p> <p>On 12/06/24 at 11:59 a.m., the DON was asked if the physician was notified when the medication was held. The DON and the Regional Nurse Consultant stated there were standing orders to hold for a low blood pressure. The Administrator stated nursing staff knew not to give the medication when the blood pressure was low.</p> <p>Standing orders to hold this medication were never provided to the survey team.</p>		

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<p>F 0772</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided.</p> <p>35389</p> <p>Based on record review and interview the facility failed to obtain physician ordered labs for two (#24 and #37) of five sampled residents reviewed for unnecessary medications.</p> <p>The Administrator identified 67 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #37 had diagnoses which included major depressive disorder, liver disease, and unspecified viral hepatitis b without hepatic coma.</p> <p>A Physician Order, dated 10/10/21, documented CBC and CMP every six months in October and April.</p> <p>There was no documentation the above October 2024 labs were collected for Resident #37.</p> <p>On 12/05/24 at 8:19 a.m., LPN #6 stated staff would note an order first, put the ordered labs in the electronic lab system to be drawn, and document the date and time the lab showed up to the facility. They stated they would print it out and verify the lab was drawn. They stated the lab tech would place a copy of what was drawn in the lab book which stayed at the nurses' station.</p> <p>On 12/05/24 at 8:21 a.m., LPN #6 stated when lab results came in, staff would look them up in the lab portal electronically. They stated the provider came to the facility on Tuesday and Thursday and staff would place the results in the communication book for them to review. LPN #6 stated if the provider did not come to the facility that day, they would call the results to the provider.</p> <p>On 12/05/24 at 8:22 a.m., LPN #6 stated after the provider reviewed the labs, they would write an order on the lab slip. They stated staff would then transcribe the order and send it to pharmacy. They stated the lab results would go in the resident's chart.</p> <p>On 12/05/24 at 8:28 a.m., LPN #6 was asked to locate the April and October 2024 lab results for Resident #37. They looked in the electronic laboratory system and were unable to locate the results. They stated they would get back with the surveyor.</p> <p>On 12/05/24 at 11:37 a.m., the DON stated they did not see the labs on the monthly orders for Resident #37. The Regional Consultant stated, They didn't tell me about that one.</p> <p>On 12/05/24 at 11:40 a.m., the DON stated the facility drew labs on new admissions when they came in. They stated long term care residents would also have labs drawn. They stated the physician would view the results and they would be placed in the chart.</p> <p>2. Resident #24 had diagnoses which included seizures.</p> <p>A Physician Order, dated 07/12/23, documented draw Keppra level every three months in July, October, January, and April.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Kingwood Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 1921 Northeast 21st Street Oklahoma City, OK 73111	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0772</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The October 2024 Keppra level results were not located in Resident #24's record.</p> <p>On 12/10/24 at 12:31 p.m., the Regional Nurse Consultant stated they did not have the October 2024 labs.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389</p> <p>Based on observation, record review and interview, the facility failed to pass ice in a manner which prevented cross contamination during one of one ice passes observed.</p> <p>The Administrator identified 67 residents resided in the facility.</p> <p>Findings:</p> <p>A Hand Hygiene policy, reviewed 07/24, read in part, . The single most important step in the prevention of infection is hand hygiene .when to use Alcohol Based Hand Rub .After touching a resident or the resident's immediate surroundings .</p> <p>On 12/03/24 at 11:11 p.m., CNA #10 was observed going into room [ROOM NUMBER] obtained a resident's personal cup, placed ice from the ice chest in it and returned the cup to the resident's room. The CNA did not wash or sanitize their hands.</p> <p>On 12/03/24 at 11:13 p.m., CNA #10 knocked on room [ROOM NUMBER] went in and offered ice to the resident, then walked into room [ROOM NUMBER] and offered ice to the residents in the room. The CNA did not wash or sanitize their hands.</p> <p>On 12/03/24 at 11:16 p.m., CNA #10 knocked on room [ROOM NUMBER] walked into the room, obtained a resident's cup from the room, placed ice from the ice chest in it, and handed the cup to the resident. The CNA did not wash or sanitize their hands.</p> <p>On 12/03/24 at 11:19 p.m., CNA #10 knocked on room [ROOM NUMBER], the residents in the room did not accept ice. CNA #10 walked into room [ROOM NUMBER] removed a cup from the room, placed ice in it from the ice chest, and took the cup back into the room. The CNA did not wash or sanitize their hands. CNA #10 walked into room [ROOM NUMBER] took a cup from the resident, placed ice in it from the ice chest, and took it back into the resident's room. The CNA exited the room, sanitized their hands and stated they were done passing ice.</p> <p>On 12/03/24 at 11:21 p.m., CNA #10 stated if more than two residents asked for ice, they would pass it out to everyone on the hall. They stated they were supposed to use hand sanitizer between residents, but they were so far apart on the hall, they tried to use it every other room.</p> <p>On 12/06/24 at 8:35 a.m., the DON stated staff were to sanitize there hands when going from room to room passing ice. They stated staff should sanitize between each resident.</p>		